Request for Family or Medical Leave

This form is used to request family or medical leave. I understand that an employee must notify the store manager of the need to take leave:

- 30 days in advance, when the need for the leave is foreseeable (e.g., planned medical treatment)
- within 2-days after the need occurs, when the need is not foreseeable (e.g., emergency hospitalization)

Employee: Jennifer L Tapscott **Date:** 3/18/16

Address: 173 Beauty hill Rd. **Store:** 36

Center Barnstead NH 03225 **Employee Number:** ~~647776~~ 14150

Phone Number: (603) 833 3868 **Badge Number:** 647776

I am requesting a leave for one of the following reasons:

X Unable to work because of my serious health condition.

_____ To care for my spouse, child or parent with a serious health condition.

_____ To care for a newborn son or daughter.

_____ To care for a child newly placed with me for adoption or foster care.

_____ For a qualified military exigency. (Examples on back of form)

_____ To care for an active military service member injured in the line of duty.

_____ Other

If other, please describe: _____

RECEIVED MAR 22 2016 By D Joyce

Length of Leave: Date leave will start if approved: 3/28/16 Date of expected return: 5/11/16

Number of hours per week needed: 45

Do you wish to use accrued sick days or vacation time during this leave? Yes_____ No X

If yes, please specify:

Sick days: _____

Vacation time: _____

I understand that the Demoulas benefits department will notify me whether this request for leave has been approved. If the leave is approved, the benefits department will send to me more details on my rights and obligations during the leave.

Employee Signature: Jennifer Tapscott **Date:** 3/18/16

Manager Signature: M. Pitt **Date:** 3/18/16

Revised 3/15

008-03 PERSONNEL FILE INQUIRY 03/22/16 09:34

NAME AND ADDRESS
TAPSCOTT, JENNIFER L
173 BEAUTY HILL RD
CTR BARNSTEADNH 03225
PHONE 603-749-1785

CLIENT 001 ACTIVE EMP NUMBER 14150
STORE 036 SOMERSWORTH BADGE NUMBER 64776
DEPT 3 PRODUCE
CLASS 47 WRAPPERS - FULL TIME SOC SEC
OLD/OTH EMP# 00000,031 14150 LIFE INS 015000
PAYMENT TYPE PC
AGE 43
SEX F
BIRTH DATE
DATE OF REHIRE
DATE OF HIRE 02/07/90
POP PLAN YES
PAY TYPE H HOURLY
PAY FREQUENCY 1 WEEKLY
EMPLOYEE TYPE H FULL TIME
HOURS WORKED YTD 464.00
DATE FULLTIME 05/30/99
DATE ADJUSTED 10/26/15
WKS LAST RAISE 22
DATE TERMINATED
TERM CODE
DATE OF EXP

LIFE/B 07/03/2013
BLUE CROSS 40.00
DENTAL 4.00
UNITED FUND 0.00
HOLIDAY 02
WEEKS EMP 905
SCHED HRS 40.00

GARNISH DEDUCTIONS

	AMOUNT	BALANCE	VENDOR	PAYOR-ID	%
1	0.00	0.00			00
2	0.00	0.00			00
3	0.00	0.00			00
4	0.00	0.00			00
5	0.00	0.00			00
9	0.00				
10	0.00	0.00			00
11	0.00	0.00			00

OVER SCHEDULED 14.25 04 HRS/WKS
SUNDAY O/T 39.0008
P/S/C Y PROF/B A/N 04/10/2015
DECLINE MED DEN HIRD SEC125
BC/BS ID 983926207 HIRD SIGN DT
VACATION EARNED 160.00 SICK DATE ELIG 02/07/1990
VACATION PAID 40.00 SICK EARNED 44 PAID 18.75
VACATION DUE 120.00 SICK CARRIED 0 AVAIL 25.25
DOC. TYPE DOC. NUMBER

ERROR:

008-41 CLIENT (001 WEEKLY HOURS YEAR (16 03/22/16 09:40
EMP NO (14150 NAME TAPSCOTT, JENNIFER L

WEEK END	HOURS	WEEK END	HOURS	WEEK END	HOURS
01/02/16	31.50				
01/09/16	3.50				
01/16/16	31.50				
01/23/16	45.25				
01/30/16	42.25				
02/06/16	41.00				
02/13/16	38.75				
02/20/16	32.25				
02/27/16	37.25				
03/05/16	32.00				
03/12/16	45.75				

TOTAL HOURS = 381.00

ERROR

008-41 CLIENT (001 WEEKLY HOURS YEAR (15 03/22/16 09:40
EMP NO (14150 NAME TAPSCOTT, JENNIFER L SSN (

WEEK END	HOURS	WEEK END	HOURS	WEEK END	HOURS
01/03/15	41.00	05/23/15	46.50	10/17/15	34.75
01/10/15	50.50	05/30/15	45.25	10/24/15	40.25
01/24/15	38.50	06/06/15	46.50	10/31/15	45.25
01/31/15	38.75	06/13/15	46.50	11/07/15	44.00
02/07/15	47.50	06/20/15	46.50	11/14/15	38.50
02/14/15	35.75	06/27/15	43.50	11/21/15	45.50
02/21/15	36.25	07/04/15	38.50	11/28/15	43.25
02/28/15	36.25	07/18/15	39.75	12/05/15	32.00
03/07/15	45.00	07/25/15	46.25	12/12/15	21.25
03/14/15	40.00	08/01/15	38.00	12/19/15	39.75
03/21/15	46.50	08/08/15	45.75	12/26/15	42.00
03/28/15	49.75	08/15/15	44.00		
04/04/15	48.00	08/29/15	40.00		
04/11/15	40.00	09/05/15	45.50		
04/18/15	37.50	09/12/15	.00		
04/25/15	46.50	09/19/15	39.50		
05/02/15	40.00	09/26/15	45.50		
05/09/15	33.50	10/03/15	47.00		
05/16/15	46.50	10/10/15	34.75	TOTAL HOURS =	2003.50

ERROR

EXECUTIVE OFFICES
875 EAST STREET
TEWKSBURY, MASSACHUSETTS 01876-1495
978-851-8000

March 22, 2016

Jennifer Tapscott
173 Beauty Hill Road
Center Barnstead, NH 03225

Dear Jennifer,

In response to your request for a leave of absence for your own serious health condition, we are providing you with the information pertaining to Demoulas Super Markets, Inc.'s Family and Medical Leave Policy. Enclosed are several forms:

- Notice of Eligibility and Rights & Responsibilities
- Employee Rights and Responsibilities under the Family and Medical Leave Act
- Certification of Health Care Provider for Employee's Serious Health Condition

Part A of the Notice of Eligibility and Rights & Responsibilities states that you are eligible for FMLA. Part B provides information about whether you are able or required to substitute paid leave for unpaid leave and any responsibilities you may have while on leave. Please read this notice carefully.

Please have your healthcare provider complete the enclosed Certification. This form needs to be completed and returned to my attention within 15 calendar days of this request. Failure to provide the required documentation may result in delay or denial of your leave.

If you have any questions, please contact me at the number provided.

Kind Regards,

Betsy Pelletier
Benefits Manager

Cc: Mr. Labatte
Store Director, #36

Enclosures

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: Jennifer Tapscott
Employee

FROM: Betsy Pelletier
Employer Representative

DATE: 3/22/2016

On 3/18/2016, you informed us that you needed leave beginning on March 28, 2016 for:

____ The birth of a child, or placement of a child with you for adoption or foster care;

✓ Your own serious health condition;

____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.

____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

✓ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.
____ You have not met the FMLA's hours of service requirement.
____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact Betsy Pelletier or view the FMLA poster located in Break Room #36.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** April 6, 2016. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

✓ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ✓ **is**/____ **is not** enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed (such as documentation for military family leave): _____

✓ No additional information requested

CONTINUED ON NEXT PAGE

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

✓ Contact Betsy Pelletier at 978-640-8352 to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

____ You will be required to use your available paid _____ **sick,** _____ **vacation,** and/or _____**other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

____ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

  _____ the calendar year (January – December).

  _____ a fixed leave year based on _____.

  _____ the 12-month period measured forward from the date of your first FMLA leave usage.

  ✓ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____ **sick,** ____**vacation,** and/or ___ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  ____For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

  ____Applicable conditions for use of paid leave:_____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

Betsy Pelletier at 978-640-8352.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Demoulas Super Markets, Inc, Betsy Pelletier, Benefits Manager 978-640-8352

Employee's job title: Produce Wrapper Regular work schedule: 40 Hours

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___Yes. If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

If so, identify the job functions the employee is unable to perform:

_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____Yes. If so, explain:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Jennifer Tapscott
173 Beauty Hill Rd
Center Barnstead, NH
03225

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) John Tapscott C. Date of Delivery 3/26/16

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0000 3030 4795

PS Form 3811, July 2013 Domestic Return Receipt

7012 0470 0000 3030 4795

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To Jennifer Tapscott
Street, Apt. No.; or PO Box No. 173 Beauty Hill Rd
City, State, ZIP+4 Barnsted NH

PS Form 3800, August 2006 See Reverse for Instructions

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Demoulas Super Markets, Inc, Betsy Pelletier, Benefits Manager 978-640-8352

Employee's job title: Produce Wrapper Regular work schedule: 40 Hours

Employee's essential job functions: _____

Check if job description is attached: ____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: Jennifer (First) Lee (Middle) Tapscott (Last)

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: Jeffrey Segil, M.D. 700 Central Ave. Dover NH 03820

Type of practice / Medical specialty:

Telephone: (603) 742-2424 Fax: (603) 740-4650

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS

1. Approximate date condition commenced: present for years

Probable duration of condition: until surgical intervention

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
✓ No ___ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
3/2/16, 3/7/16

Will the patient need to have treatment visits at least twice per year due to the condition? ✓ No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___ No ✓ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
✓ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ✓ No ___ Yes. If so, expected delivery date: ___

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ___ No ✓ Yes.

If so, identify the job functions the employee is unable to perform:
Completely out of work for surgical recovery

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
pelvic pain

CONTINUED ON NEXT PAGE

PART B AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ✓Yes.

If so, estimate the beginning and ending dates for the period of incapacity: 3/30/16 - 5/13/16

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ✓No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
____ No ____ Yes. If so, explain:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

_____

_____

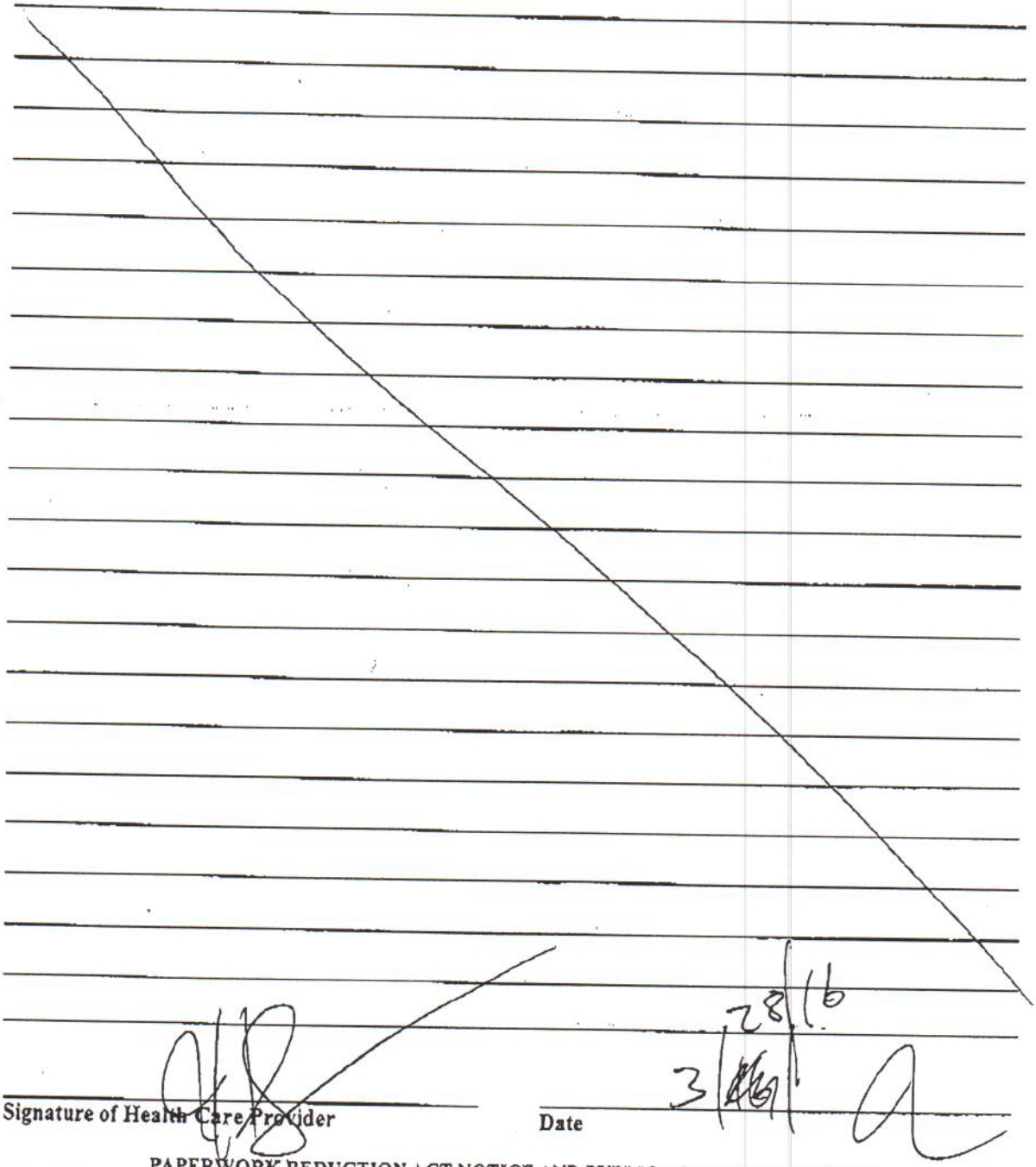
_____

_____

_____

_____

CONTINUED ON NEXT PAGE



Signature of Health Care Provider

Date 3/28/16

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

DOVER WOMEN'S HEALTH, P.A.
700 CENTRAL AVE.
DOVER, NH 03820
Telephone: 603-742-2424 FAX: 603-740-4650

FAX COVER SHEET

To: Betty Pelletier From: Deb F

Company: Market Basket # pages including cover: 5

Telephone 978-640-8352 Date 3/29/16

Fax: 978-640-8374 Time: 2:18 pm

RE:

The documents accompanying this fax contain Confidential Medical Information, which may be legally privileged and exempt from disclosure under applicable law. The information is intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action with the respect to the contents of this faxed information except if directly delivered to the intended recipient named below is strictly prohibited. If you have received this fax in error, please notify us immediately by telephone and destroy the faxed document.

EXECUTIVE OFFICES
875 EAST STREET
TEWKSBURY, MASSACHUSETTS 01876-1495
978-851-8000

March 29, 2016

Jennifer Tapscott
173 Beauty Hill Road
Center Barnstead, NH 03225

Dear Jennifer:

Enclosed is the Designation Notice related to your request for Family and Medical Leave. It identifies the status of your request. It also provides information about other matters related to your leave, such as your leave schedule and any required Return to Work Certification. Please read the Notice carefully.

If you have questions about this, please contact me at 978-640-8352.

Kind Regards,

Betsy Pelletier
Benefits Manager

Cc: Mr. Labatte
Store Director, #36

Enclosures

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: Jennifer Tapscott

Date: 03/29/2016

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on 3/29/2016 and decided:

✓ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

✓ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: up to 12 weeks

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

✓ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ✓ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

Form WH-382 January 2009

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Jennifer Tapscott
173 Beauty Hill Rd
Center Barnstead, NH
03225

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name) John Artesi | C. Date of Delivery 4-1-16

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0000 3030 9158

PS Form 3811, July 2013 Domestic Return Receipt

7012 0470 0000 3030 9158

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To Jennifer Tapscott
Street, Apt. No.; or PO Box No. 173 Beauty Hill Rd
City, State, ZIP+4 Center Barnstead NH

PS Form 3800, August 2006 See Reverse for Instructions

DOVER WOMEN'S HEALTH
PROFESSIONAL ASSOCIATION

Jeffrey M. Segil, M.D., F.A.C.O.G.
Anna M. DeYoung, M.D., F.A.C.O.G.
Julie A. Bleyenberg, D.O., F.A.C.O.G.

[illegible] Martin, C.N.M., M.P.H.
[illegible], C.N.M., M.P.H.
Christine [illegible] Bryant, C.N.M., M.S.N.
Lisa [illegible] Husted, C.N.M., M.S.N.
[illegible] Labreck, C.N.M.
Rachel Morgan, C.N.M.

05/04/2016

Jennifer Tapscott
173 Beauty Hill Road
Center Barnstead, NH 03225
Patient Name: *Tapscott, Jennifer*

To Whom It May Concern:

Jennifer Tapscott is under our medical care and may return to work on 05/16/2016 without restrictions.

If you need any further information, please contact our office.

Jeffrey Segil, M.D.
Dover Women's Health
603-742-2424

cc:
enc:

700 Central Avenue · Dover, NH 03820 · Telephone [illegible] · Fax [illegible]

EXECUTIVE OFFICES
875 EAST STREET
TEWKSBURY, MASSACHUSETTS 01876-1495
978-851-8000

May 26, 2016

Jennifer Tapscott
173 Beauty Hill Road
Center Barnstead, NH 03225

Dear Jennifer,

We are in receipt of your recent doctor's note stating you will be out on leave again. Enclosed is the designation notice that identifies the status of your request as well as other matters related to your leave, such as your leave schedule and any required Return to Work Certification. Please read the Notice carefully.

If you have questions about this, please contact me at 978-640-8352.

Kind Regards,

Betsy Pelletier
Benefits Manager

Cc: Mr. Labatte
Store Director, #36

Enclosures

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2018

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: Jennifer Tapscott

Date: 05/26/2016

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We received your most recent information on May 26, 2016 and decided:

✓ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

✓ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: up to 5 weeks

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

✓ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ **is** ✓ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Jennifer Tapscott
173 Beauty Hill Rd.
Center Barnstead, NH
03225

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☑ Addressee

B. Received by (Printed Name) Jennifer Tapscott C. Date of Delivery 5/28/16

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☑ No

3. Service Type
☑ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☑ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 0470 0000 3029 2764

PS Form 3811, July 2013 Domestic Return Receipt

7012 0470 0000 3029 2764

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To Jennifer Tapscott
Street, Apt. No.; or PO Box No. 173 Beauty Hill Rd.
City, State, ZIP+4 Center Barnstead, NH 03225

PS Form 3800, August 2006 See Reverse for Instructions

DOVER WOMEN'S HEALTH
PROFESSIONAL ASSOCIATION

Jeffrey M. Segil, M.D., F.A.C.O.G.
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Patricia L. Martin, C.N.M., M.P.H.
June Dysinger, C.N.M.,M.P.H.
Christine L. Brant, C.N.M.,M.S.N.
Lisa Jaramillo-Husted, C.N.M., M.S.N.
Traci Labreck, C.N.M.
Rachel Mergen, C.N.M.

06/15/2016

Jennifer Tapscott
173 Beauty Hill Road
Center Barnstead, NH 03225
Patient Name: *Tapscott, Jennifer*

To Whom It May Concern:

Jennifer Tapscott is under our medical care and may return to work on 06/22/2016 without restrictions.

If you need any further information, please contact our office.

cc:
enc: